GRAND STRAND PEDIATRICS & ADOLESCENT MEDICINE, P.A.

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize GRAND STRAND PEDIATRICS & ADOLESCENT MEDICINE, P.A. to Use or Disclose my Protected Health information as described below. I understand that the information I authorize a person/facility to receive may be re-disclosed and no longer protected by state and federal regulations.

***** PLEASE MAIL ANY MEDICAL RECORDS OVER 25 PAGES *****

Patient Name_____
First Middle Last

Address_____
Street City State ZipCode

Phone#_____ DOB_____ Gender: (M)_____(F)_____

Name of Person/Facility authorized to RELEASE the information _____
Address:_____Telephone:_____Fax:_____
_____

Name of Person/Facility to RECEIVE the information :
Phone: 843-249-7400 Fax: -843-249-7440

Grand Strand Pediatrics
4326 Baldwin Ave
Little River, SC 29566

Purpose of Disclosure:_____
Dates of Treatment: _____

INFORMATION TO BE USED/DISCLOSED-Please check those that apply.
__Consultation Summary __Discharge Summary __Entire Medical Record __Pathology Report
__History & Physical __Immunization Records __Laboratory Report __Operative Report
__Progress Report __Radiology Report __Other (specify)_____

I understand that in the event I was treated for drug or alcohol abuse, psychiatric condition, communicable disease including HIV/AIDS this information will be included as part of my medical record to the above named person/facility.

This office may not condition treatment, payment, enrollment, or eligibility for benefits on signing this authorization. This authorization is subject to cancellation/revocation at any time, by the patient or legally qualified representative provided that the cancellation is made in writing except to the extent that: (1) the Facility has already acted on your request prior to receiving the request to cancel the authorization or (2) If the authorization was given to release records to your insurance company in order to obtain insurance coverage. This authorization will automatically expire in 90 days unless otherwise stated. Expiration Date_____.

Signature of Patient or Legally Qualified Representative_____DOB:_____
Relationship to Patient_____
Printed Name_____ Date:_____